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377

# BRITISH MEDICAL JOURNAL



SATURDAY 15 NOVEMBER 1969

## LEADING ARTICLES

- Academic and Professional Freedom page 379    Oral Contraception and Depression page 380  
Urinary Symptoms in General Practice page 381    Treatment with Neutrons page 381  
Psychogenic Dyspnoea page 382    Immunological Aspects of Addison's Disease page 382  
Anaesthesia in the Dark page 383    Actinic Reticuloid page 384    Invasion of Privacy page 384

## PAPERS AND ORIGINALS

- Medical Education and the State    RONALD V. CHRISTIE ..... 385  
Epidemiology of Urinary Tract Diseases in General Practice  
J. STEENBERG, E. D. BARTELS, H. BAY-NIELSEN, E. FANØE, AND T. HEDE ..... 390  
Feto-maternal Haemorrhage in Therapeutic Abortion    J. C. VOIGT AND R. P. BRITT ..... 395  
Insulin Sensitivity and Vascular Disease in Maturity-onset Diabetics    A. E. STOCKS AND F. I. R. MARTIN ..... 397  
Mechanism of Action of  $\beta$ -Adrenergic Receptor Blocking Agents in Angina Pectoris: Comparison of Action of  
Propranolol with Dextropropranolol and Practolol    A. G. WILSON, O. G. BROOKE, H. J. LLOYD, AND B. F. ROBINSON ..... 399  
Association of Hypokalaemia and Hypophosphataemia    D. C. ANDERSON, T. J. PETERS AND W. K. STEWART ..... 402  
Involuntary Movements in Patients Taking Oral Contraceptives    P. D. LEWIS AND M. J. G. HARRISON ..... 404  
Active Immunotherapy in Treatment of Acute Leukaemia    R. J. GUYER AND D. CROWTHER ..... 406

## PRELIMINARY COMMUNICATIONS

- Nasal Mucosal Absorption of Tetracosactrin as Indicated by Rise in Plasma Fluorogenic Corticosteroids  
J. KEENAN AND M. A. CHAMBERLAIN ..... 407

## MEDICAL MEMORANDA

- Transient Hypertension Caused by Segmental Renal Artery Occlusion  
H. B. BENRAAD, TH. J. BENRAAD, AND P. W. C. KLOPPENBORG ..... 408

## MIDDLE ARTICLES

- Cogwheel: A Physician's View of a Local Version  
JAMES S. STEWART ..... 420  
Emergency Admissions to a General Medical Unit:  
A Survey of the Accompanying Letters, with  
Recommendations    P. K. BARNES AND R. W. HOILE... 424  
Personal View    C. R. B. JOYCE..... 426

## BOOK REVIEWS..... 417

## NEWS AND NOTES

- Parliament ..... 439  
Epidemiology ..... 439  
Medico-Legal ..... 440  
Medical News ..... 440

## CURRENT PRACTICE

- Migraine    ALICK ELITHORN..... 411  
Spinal Injuries and Fractures    J. ASHWORTH..... 414  
Any Questions? ..... 415

## CORRESPONDENCE ..... 427

## OBITUARY NOTICES..... 436

## SUPPLEMENT

- Hospital Junior Staffs Group Council ..... 37  
Safeguarding Junior Staffs' Interests: Chairman of  
Council's Letter ..... 39  
Occupational Health Committee ..... 39

# Correspondence

*Letters to the Editor should not exceed 500 words.*

## Computers on the March

- M. P. McBrien, F.R.C.S.; R. de Soldenhoff, B.Sc. ....427
- Mobile Coronary Care Teams**  
A. A. Jennifer Adgey, M.R.C.P., and S. A. Zaidi, M.R.C.P.I. ....427
- Car Driving and the Heart**  
G. Wiseman, M.D.; H. Franks, D.P.H. ....428
- Treating Preinfected Wounds**  
J. A. Raeburn, M.B.; P. J. Whitfield, B.A.; A. G. Zermansky ....428
- Renal Transplantation and Leucocyte Migration**  
W. J. Dempster, F.R.C.S. ....428
- Vaccination against Whooping-cough**  
F. T. Perkins, Ph.D. ....429
- Acetate and Bacteria**  
I. Kennedy, M.B. ....430
- Saving the Grossly Disabled**  
R. C. Sanders, M.R.C.P. ....430
- Purpura and Ibuprofen**  
T. Ward, D.C.H. ....430

## Career Prospects for Medically Qualified

- Dentists**  
F. G. Hardman, M.B., F.D.S. R.C.S. ....430
- Agricultural Accidents**  
R. M. Archibald, D.I.H. ....430
- Fibrinolytic Enzyme System**  
J. Bonnar, M.R.C.O.G., and others ....430
- Analgesic Nephropathy**  
D. Bell, M.B., and others ....431
- Malignant Granuloma**  
I. Friedmann, F.C.PATH., and D. A. Osborn, F.C.PATH. ....431
- Battered Babies**  
B. Barnett, D.P.M. ....432
- Metabolism in Parkinsonian Patients**  
J. Braham, M.D., and A. Szeinberg, Ph.D. ....432
- Survival after 195 Defibrillations**  
M. M. Kubik, M.D., and P. K. Das Gupta, M.R.C.P.E.D. ....432
- Methoxyflurane for Obstetric Analgesia**  
M. Rosen, F.F.A. R.C.S., and others ....432
- Clinical Data and Statistical Interpretation**  
J. S. Price, D.P.M. ....433

## Inappropriate Lactation

- R. P. Shearman, F.R.C.O.G. ....433
- Congenital Anomalies of the Vas Deferens**  
G. T. Watt, F.R.C.S. ....433
- Unwanted Blessings**  
P. H. Addison, M.R.C.S. ....433
- Solitary Confinement**  
R. I. K. Blyth, M.R.C.S. ....433
- The Consultant's Job**  
D. St. C. L. Henderson, F.R.C.S.ED., and others; M. Hamilton, F.R.C.P., and others ....434
- Regional Hospital Medical Staff**  
G. G. Muir, M.D. ....435
- Specialist Registration and the Armed Forces Surgeon Commander**  
G. A. R. Giri, D.P.H. ....435
- Postgraduate Courses and Seniority**  
H. G. Gibson, M.B. ....435
- Fees for Expert Witnesses**  
G. F. Petty, M.R.C.S. ....435
- Christmas Gifts Fund Appeal**  
Sir Thomas Holmes Sellors, P.R.C.S. ....435

## Computers on the March

SIR,—Your leading article "Computers on the March" (18 October, p. 124) highlights only a few of the problems of introducing computers into medicine. Dr. J. H. Mitchell (18 October, p. 157) underlines two basic difficulties, which I believe will prevent the computer from intruding further into the clinical field.

Firstly, the history obtained from most patients in a busy outpatient department or ward is likely to be put together in a somewhat disjointed fashion; this depends on the mutual concentration, interest, and experience of the doctor on the one hand and the ability to communicate, the actual illness, and the state of mental anxiety of the patient on the other. The resulting data are bound to be "vague and unreliable," to quote Dr. Mitchell, and can never be suitable for computer input. Conversion of these human facts into "standard" questions and "standard" answers requires a vast increase in secretarial and programming personnel, a great deal of added "time per patient," and is plainly unworkable in the National Health Service.

Secondly, the record of examination of a patient can only contain certain parameters of objective assessment—for example, temperature, pulse, blood pressure—and these can be notoriously unreliable at a first interview. Other findings at a preliminary, and often cursory, examination are purely subjective, and depend considerably on the skill, experience, and individual variation among doctors. Such data are likewise unsuitable for programming a computer.

In certain areas of hospital work computers are invaluable, but in the strictly clinical field I feel that the only time that the medical profession will consent to using a common terminology of computer language will be when "standard" doctors are turned

out at the end of "standard" courses from "standard" medical schools, and when their patients stop being human.—I am, etc.,

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SIR,—After a rather tardy start the medical profession in Great Britain is seriously contemplating the use of computers in this the most conservative of professions. As Dr. M. Marinker points out<sup>1</sup> there are several studies going on in general practice attempting to computerize records. A number of Scottish and English hospitals have tried to computerize small areas of their records.<sup>2</sup>

Dr. D. E. Clark<sup>3</sup> tells us that 75% of the activity of a hospital is concerned with the processing of information. Jydstrup and Gross<sup>4</sup> inform readers that the present cost of a hospital's information system or processing techniques is much higher than we appreciate, and may be as much as 25% of the total hospital operating budget.

It is indeed disappointing to see the article by Dr. J. H. Mitchell (18 October, p. 157), a distinguished expert on the processing of medical records, in which he condemns exciting research and investigation into this field as "fantastically elaborate and expensive." When the process of recording and retrieval of information is of such importance, then expensive schemes are valid. The storage of many patient-years of information is a simple and economical computer process, and destruction of records may well meet with condemnation from our successors in their studies or topics of interest and research into our diseases of the 60's and 70's. Our danger is not the diversion of attention from

more valuable uses to which computers might be put, but reluctance to spend time and effort on the resources at hand and to learn how to use them to their full efficiency.—I am, etc.,

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- Kennedy, F., Roy, A. D., Cleary, J. J., and Kay, A. W., *Lancet*, 1968, 2, 1230.
- Clark, D. E., *Practitioner*, 1969, 203, 313.
- Jydstrup, R. A., and Gross, M. J., *Health Services Research*, 1966, 1, 235.

## Mobile Coronary Care Teams

SIR,—We believe that it would be singularly unfortunate if the concept of prehospital coronary care were to be judged by the results reported by Dr. H. A. Dewar and his colleagues (25 October, p. 226). The poor results obtained by the Newcastle unit, in contrast to the results obtained by the Belfast Mobile Coronary Care Unit,<sup>1-4</sup> are due to fundamental differences in the operation of the units.

In Belfast the emphasis is on early initiation of coronary care; thus the median time between onset of symptoms and the initiation of coronary care by the mobile unit is two hours, and 26% of the patients managed by the Belfast unit are under intensive care within one hour. In contrast, the mean time quoted by Dr. Dewar and his colleagues is four and a half hours. Since the majority of deaths from myocardial infarction occur within two hours of the onset of symptoms, the Newcastle unit will have little effect on the mortality. It appears that the general practitioners of Newcastle upon Tyne have been ill informed as to the type of patient who is most likely to benefit from immediate